Methodist Sports Medicine
THE ORTHOPEDIC SPECIALISTS

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION RELEASE OF RECORDS

FIRST NAME:_____ MI:_____ LAST NAME:_____ DATE OF BIRTH:_____

PRIMARY PHONE:_____ SECONDARY PHONE: _____

HOME ADDRESS:_____ CITY/STATE/ZIP:_____

If you are not an athlete involved in a school sport program, skip Section A.
Otherwise, please fill in the name of your school or league program.

SECTION A: SPORTS AUTHORIZATION

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed by Methodist Sports Medicine / The Orthopedic Specialists includes any and all medical data, documents, or consultation reports related to the athlete's physical fitness to practice or to engage in any school / league related sport(s).

Purpose of this Authorization/Entities Authorized: By signing this form, you authorize us to disclose to: _____
School and/or League Name
and its coaches, athletic trainers, athletic director and staff, the protected health information described above to enable the school to determine the athlete's fitness to practice and participate in school / league sports.

Expiration: This authorization will expire upon (a) the termination of the athlete's eligibility to participate in school sports, according to school and IHSAA, National Federation of State High School Association, or other school or league policies, as amended from time to time of (b) revocation of this authorization as described below.

SECTION B: FAMILY AUTHORIZATION

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed by Methodist Sports Medicine / The Orthopedic Specialists includes any and all medical data, and appointment or billing information related to your treatment by Methodist Sports Medicine / The Orthopedic Specialists.

Authorized Person:_____ Relation:_____ Contact number:_____
_____ Relation:_____ Contact number:_____
_____ Relation: _____ Contact number:_____

Expiration: This authorization will remain in effect until revocation of this authorization as described below.

SECTION C: CONDITIONS

No conditions: This authorization is voluntary. We will not condition treatment on receiving this authorization.

Effect of granting this authorization: The protected health information described above may be disclosed to and/or received by the organization(s) designated above, who are not subject to federal health information privacy laws. Such organization(s) may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION D: REVOCATION

Right to revoke: You may revoke this authorization at any time by giving written notice of revocation to the contact listed below. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your written notice of revocation. If applicable, Methodist Sports Medicine / The Orthopedic Specialists will inform your school of any revocation of this authorization.

Contact Information: Privacy Officer
Methodist Sports Medicine / The Orthopedic Specialists
201 Pennsylvania Parkway, Suite 100
Carmel, IN 46280
Telephone: 317.817.1200

SECTION E: INDIVIDUAL SIGNATURE

I acknowledge and agree that (a) I have had a full opportunity to read and consider the contents of this authorization and (b) the information provided above is accurate. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of protected health information, as described in this form. ***** You are entitled to a copy of this authorization after you sign it *****

Signature of Patient:_____ Date:_____

Signature of Personal Representative of if Patient is a Minor: _____

Relationship to Patient:_____